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ABSTRACT

This conference examined both past and potential results of a mental health rehabilitation program serving members of a New York clothing union. This research-demonstration project, which is being conducted by the Sidney Hillman Health Center with union and management cooperation, represents an attempt to keep emotionally disturbed blue collar workers on the job. This requires identifying the emotionally disturbed worker and inducing him to seek help, as well as determining what treatment is required. The conference analyzed the need for coordination of government, labor, and community mental health programs. (BH)

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Helping Blue-Collar Workers in trouble

a report of a labor-mental health conference

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1

SIDNEY HILLMAN HEALTH CENTER OF NEW YORK

ED057177

HELPING BLUE-COLLAR WORKERS IN TROUBLE:

A Report of a Labor-Mental Health Conference

New York City
September 1967

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182

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A Report of a Labor-Mental Health Conference

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The Sidney Hillman Health Center Mental Health-Rehabilitation Project was supported, in part, by research demonstration grants, number RD-1453-G, Rehabilitation Services and number 1523, National Institute of Mental Health, both of the Department of Health, Education, and Welfare, Washington, D.C.

DEDICATION

These proceedings are dedicated to the late Dr. Morris Brand, a guiding light and inspired leader in the labor health field. His untimely death left a great void in the ranks of all those dedicated to better care for America's working men and women.

1907 — 1968

ACKNOWLEDGMENTS

This conference is a reflection of the way new sectors of the community are responding to the mental health needs of industrial workers. We wish to thank the representatives of labor, government and the mental health professions whose concern and commitment made this significant meeting possible. The proceedings which follow, although not complete, represent the essence of a day-long attempt to share experience and define issues. They are offered as a point of departure for those interested in evolving new ways of organizing mental health services to meet the unmet needs of the 18 million working individuals represented by trade unions.

We wish to thank Miss Corinne Schreider for her creative efforts in editing the first hand comments to capture the flavor as well as the content of this session. We thank Louis Hollander and Vincent Lacapria, Managers, and the staff of the New York Joint Board, Amalgamated Clothing Workers of America for supporting the idea of this conference. We are deeply indebted to the Rehabilitation Services and the National Institute of Mental Health for the funding and guidance they have provided throughout the course of the Mental Health-Rehabilitation Project.

HIGHLIGHTS

Keeping blue-collar workers with emotional problems on the job has been the focal concern of the Mental Health-Rehabilitation Program at the Sidney Hillman Health Center. In September 1967, the project gathered together representatives of labor unions, the professions and government

> *to report on its own experiences treating the membership of the New York Joint Board, Amalgamated Clothing Workers of America,*
>
> *to permit an exchange of ideas concerning mental health services for industrial workers who need help.*

The following are the highlights of that meeting:

In their own way, labor unions have always been in the mental health business. A professional mental health team will find a direct and effective machinery for reaching the members by tapping into the union resources already there (an interested business agent,* a newspaper, a health center, an insurance company, etc.)

> *The union can help find potential patients.*
>
> *The union can fill in information necessary to understand the patient.*
>
> *The union can transfer the patient's trust to the mental health team.*

Where the mental health goal is visualized as keeping the worker on the job, "treatment" becomes all those acts which contribute to helping the patient stay at work.

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* *A Business Agent is a paid Union employee, assigned to handle labor-management problems in a group of factories under his jurisdiction.*

Union representatives contribute by becoming active participants around resolution of job maintenance problems.

Clinic structures contribute by being organized to reflect the style of life of working people

easy access to treatment
immediate care
night-time hours
foreign language therapists

Blue-collar workers tend to come for help to relieve an immediate crisis.

Paying for care under these conditions is unnecessary to motivate patients.

Goals of immediate symptom relief provide adequate motivation to keep most blue-collar workers in treatment.

Unions, by connecting continued job rights with participation in treatment, can help "motivate" the patient.

Unions alone cannot do the job. They require extensive services from the community.

The forms of such liaison can differ from back-up mental health services to contractual provisions for total care.

The community facility stands to benefit when its professional staff gets involved with a blue-collar population — barriers and misconceptions tend to break down.

The union can protect patients by acting to coordinate the fragmented psychiatric services available in the community.

There are too few mental health programs to service the needs of industrial workers.

WHO SPONSORED THE CONFERENCE?

The Mental Health Rehabilitation Program of the Sidney Hillman Health Center . . . a research-demonstration project set up three years ago to serve the 30,000 members of the New York Joint Board of the Amalgamated Clothing Workers of America. Its purpose — to find out if and how a union can help spot workers with emotional problems, get them into treatment and keep them working.

This project called for, and has had, the cooperation of the institutional arms of the clothing industry.

The union. Which provided not only the commitment, but the resources of its officers and its staff members.

The health center. Which offered the facilities of an outpatient clinic jointly sponsored by union and management, plus the experience of an earlier successful demonstration of a physical rehabilitation program.

The New York Clothing Manufacturers Association, and individual member firms.
The Amalgamated Insurance Fund.

In addition to expenditures provided by the Sidney Hillman Health Center, the program has been partially supported by grants from the Rehabilitation Services and the National Institute of Mental Health.

And in 1967, as the Mental Health-Rehabilitation Program entered the fourth year of its research activity, it held this Conference.

WHY A CONFERENCE?

The Mental Health-Rehabilitation Program isn't the only union-sponsored program in New York City trying out ways of getting help for workers with emotional illness. There are others, working along lines tailored to their individual unions' circumstances. There are also some mental health treatment facilities in the New York community which are making special efforts to reach the too-often-neglected labor population.

Now, out of the experiences of all these pioneering groups taken together, a body of hard information is beginning to emerge, worth being looked at, thought about, discussed. Not only worth it, but in fact requiring it. So the Mental Health-Rehabilitation Program called a Conference . . .

Morris Brand, M.D.,
Conference Chairman,
Medical Director,
Sidney Hillman Health Center

To tell what we did — a frank presentation of what worked, what didn't work, and some of our notions as to possible reasons.

To give an opportunity to learn what others have been doing — an open platform for exchanging experiences.

To explore new ways for labor and the mental health field to work more closely together — an honest discussion of mutual needs, special interests and common goals.

To break down the barriers which have made it impossible, too many times, for workers to get care for their mental health needs.

THE CONFERENCE PROGRAM

The plan for the Conference was, like the project sponsoring it, an experiment and demonstration.

Hyman Weiner, D.S.W.
Director, Mental Health-Rehabilitation Project
MHRP

We didn't invite you to come together to have a general meeting about the virtue of mental health. We've had enough of those, and we've had enough of the typical kind of project report — a healthy, heavy, frankly deadly document that's very good reading between twelve and one in the morning, because you're guaranteed a good night's sleep after it. What happens to it? It fills up the files, and I really think the only portion of the population that benefits is our brothers in the printers' union.

Instead, the Conference program shared the highlights of the experimental Mental Health-Rehabilitation Program by letting those who had been involved tell about their part of the action in their own informal way. Others could join in at any point to describe how they were doing similar things using different methods. The rest of the audience was free to question and discuss at will. They were asked to keep in mind only two points:

Hyman Weiner

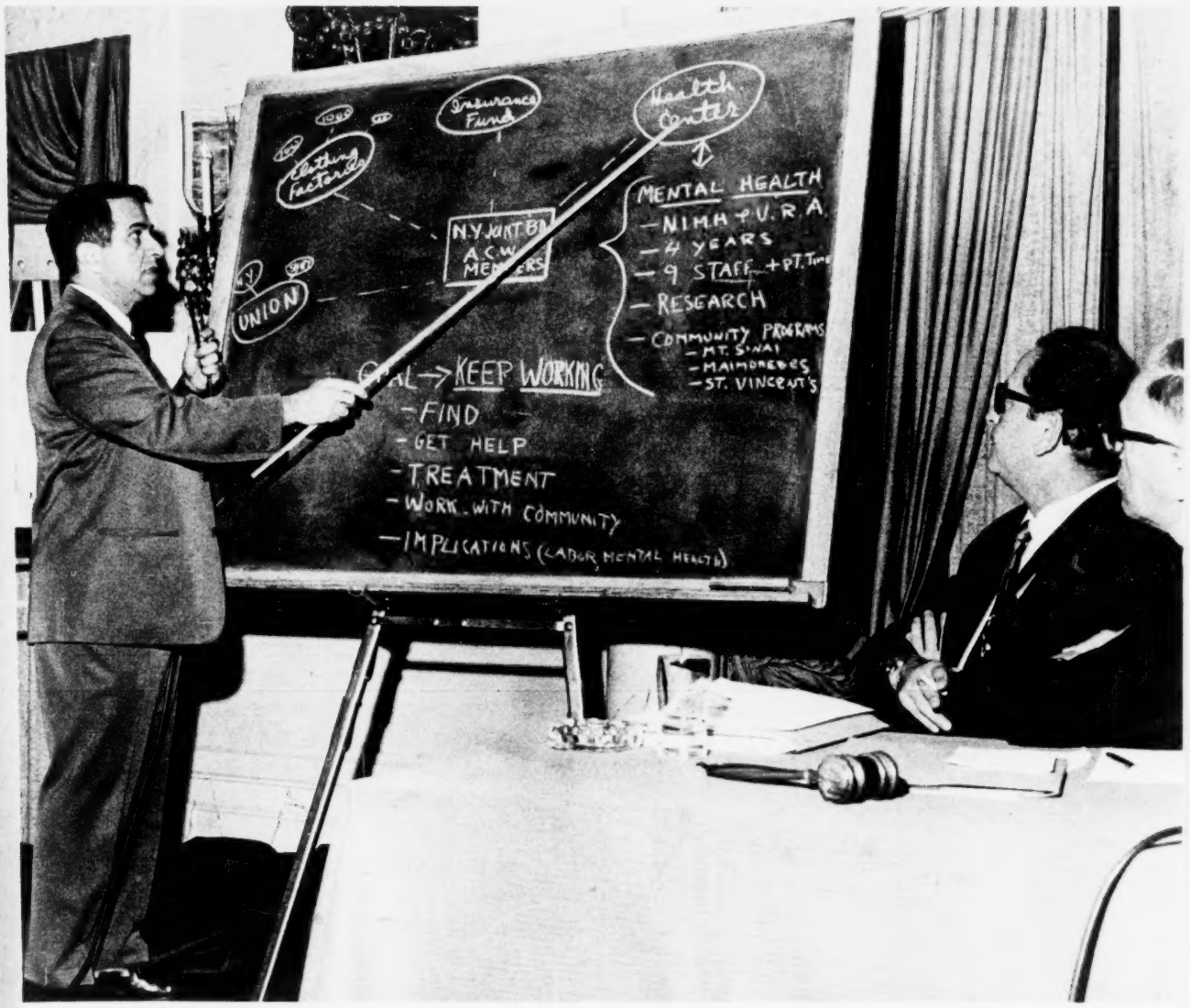
First, our emphasis in this project has been on keeping workers on the job. This hasn't been a demonstration of a comprehensive mental health program. We haven't given primary attention to the problems many of us have in our families — with teenagers, marital difficulties, spouses who have serious breakdowns — the problems of living that all of us have to a greater or lesser degree. Our primary focus has been on vocational rehabilitation. To identify the conditions under which a person with an emotional problem can continue on the job. And to learn how labor people and mental health people can work together, if indeed they can, towards this goal.

Second, we're not offering this experimental program to you as something that can be — or should be — duplicated in its entirety. Because there's no industry that's the same, no labor union that's the same, no mental health program that's the same. But we do think this program has some aspects that could be adapted to other union settings.

And with that, the Conference got down to busniess. To asking — and trying to answer — five questions: *How do you find people in trouble? How do you get them to accept help and go for help? What does treatment look like? How can community mental health facilities become involved? What are the implications for labor?*

HOW UNIONS USE THEIR KNOW-HOW TO FIND PEOPLE IN TROUBLE

First of all, it was pointed out, the fact is that labor has always been in the mental health business. In the sense that:



HYMAN WEINER, *Director Rehabilitation-Mental Health Program, S.H.H.C.*

"First, our emphasis in this program has been on keeping workers on the job."

Hyman Weiner

Every time a business agent takes up a grievance, this increases the worker's self-respect — "self-esteem," as the mental health professionals say, which is important, because when your self-esteem begins to be corroded, you're a good candidate for either a breakdown or becoming a quiet sufferer. Plus, every time the union gets involved in extending its insurance program, it's promoting the worker's well-being. Because as an antidote for mental illness, there's a lot to be said for "when in doubt, send money." It's a fact that recently (as the Conference itself is evidence), labor has been beginning to take on new responsibilities in the field of mental health. And the Mental Health-Rehabilitation Program had been able to involve the union machinery in its activities.

John J. Sommer, M.S.S.
Associate Director, MHRP

For three years we'd been working in physical rehabilitation and we had a series of contacts, informal contacts, with business agents — we knew each other. But it was only on this mental health project that the union formalized their activity.

Murray Goldstein,
Trade Manager, N.Y. Joint Board, Amalgamated Clothing Workers of America ACWA

The project was defined as something to provide better service for our membership, and since the business agents were so close to the membership, the management of the N.Y. Joint Board decided that they were the ones who should be involved, to serve in a dual role, not only as somebody to work on industrial problems within the shop, but at the same time to act as "industrial doctors" as Brothers Lacapria and Hollander phrased it. That was in March, 1966.

And I think that in the year-and-a-half since that decision, it's become a dedicated project for those of our boys who were assigned to work on it.

We've been happy to serve. Maybe for selfish reasons on our part — because it's created a much better atmosphere in the shops. We've been able to help these people who have mental and vocational problems. Maybe we've done more for them than for people who are healthy.

3/4

From left to right . . . Robert Navarre, M.D. — Morris Brand, M.D. — Murray Goldstein — Sam Shniter — Nick LiCausi — Harry Gordon and John J. Sommer

"How can I tell someone in trouble that he needs help?"—NICK LICAUSI

After the New York Joint Board put this arrangement into operation, the project had to decide what to do about training. Should it organize a formal education program, with the usual lectures on what is mental health, and how do you recognize emotional problems? This was rejected in favor of informal education: meetings every two weeks (later, monthly) at which the business agents talked about their experiences in finding and helping people in trouble.

Nick LiCausi,
Business Agent,
N.Y. Joint Board
ACWA

When I first came in on this project, I was kind of skeptical. How could I tell someone in trouble that he needs help? Suppose I really get a nut who hits me over the head if I tell him to go to a psychiatrist? I was concerned. But it worked out all right. It turned out finding people isn't hard at all, because when a business agent goes into a shop, he knows his people and the way they act — the way they talk when they're well. So you know right away when they're not well, because they're not talking the way they usually do.

My first case was the most interesting to me. I got a call from an employer saying, "I'm going to fire this kid. He's threatening everyone and his work isn't good. He starts sewing from the bottom on one piece, another piece from the top." He didn't want him in the shop. Well, I went to see him at work and asked him what the problem was. He said everybody in the shop was talking about him. I said, "Do you hear them talking about you?" He said, "No, but I can tell." He said how if they touched their ear, it meant one thing, or when they touched their nose, it meant another thing. I said, "Look, I think you're imagining things. We have a health center where we have doctors. By just talking to you they'll be able to help you." He gave me an argument, and the employer wanted to fire him, but I promised I'd take care of this kid myself — I'd get him to a doctor. Finally, he did consent to go. But he didn't keep the appointment — two or three times he didn't keep it.

Then one afternoon, somebody pressed the

5/6

panic button in the shop. This boy had become violent and he'd thrown something. I went there right away and I said, "I'm not going to talk to you as a brother anymore, I'm going to talk to you as a father. Either you come with me immediately to the doctor, or you're out of a job. We can't keep you here any more." That frightened him. He came along with me to the health center, and he was under treatment for a while. And now I want to report this young man is much better — it gave me a great sense of satisfaction.

It was reported that some business agents had been reluctant at first to be identified as the person who referred a worker for treatment. But learning from experiences like Nick LiCausi's, they began to feel more comfortable in their new roles.

Sam Shniter,
Business Agent,
N.Y. Joint Board
ACWA

All of us used to talk at staff meetings that a business agent can't be only a business agent — just somebody to come in and settle a case or a grievance between the employee and the employer. A business agent has to go deeper a little bit and involve himself with the people in his shop — to gain their confidence and to see what's troubling them.

I had a case which concerned a lady from Puerto Rico. A good worker, she earned a nice living — all of a sudden I get a call from the shop, she isn't coming in on the job a few times a week, she's leaving early, she can't be depended on.

I came to the shop, and she tells me she's sick, her head hurts her, she's been taking off from work to go to the health center for treatments. I fix things up with her boss then, but a few weeks later, the manager of the factory calls me and wants to fire her. I said, "Hold on. Let me find out." The worker had an appointment at the health center that day and I asked her to come and see me in my office after she finished there. She came, and all she could say is some-

16

thing's bothering her. I said, "Don't be afraid. Tell me. Maybe I can help you." So she tells me about her father. An elderly man — who went to the movies one night and coming home, a bunch of boys jumped him and he was killed. There were other problems in the home, too, so I said to her, "Now listen. You need a little different kind of help. I'm going to see what we can do about it." Right away I called the mental health-rehabilitation project and they said they'd see her, so she went straight back to the center and her treatment started that day.

Now this lady's back on the job and productive. She always used to be a loner in the shop, isolated, not talking to anybody — now when I come in the shop, she has a smile. She tells me, "You know, Mr. Shniter, now I feel a sense of belonging, that somebody cares about me. I'm very happy, and thankful I'm able to continue working." And that's my whole objective as a layman — that this woman should be able to work — come back on the job, be able to contribute her weekly earnings to the family. I don't know if she's completely cured. But she's working, she's productive and I'm happy to see her that way.

While some of the mental health professionals present at the Conference may have had private reservations about the business agent's forthright approach, no questions were raised. Perhaps because the project's focus was clear: not to train laymen to take on therapeutic roles, but to show how the business agent *in his own role as a union official,* can help worker-patients.

The experiences related by the business agents demonstrated possibly the most interesting and provocative of the case finding methods reported to the Conference. Obviously, the day-to-day personal contact between the agent, the shop chairman and the worker was a vital element in helping patients over a formidable hurdle: that of actually accepting a kind of treatment strange and unfamiliar to them.

Such a link, it was noted, is missing for union members whose emotional disabilities may have already taken them off the job. However, this group could be located at least through another industrial link: the insurance fund.

Dena Wechter,
Amalgamated Insurance Fund Administrator

We try to catch a claim at its inception, so we can refer the case to the health center even before it's processed. We fill out a form notifying the project that a worker has a mental health problem, and the project sends a letter to the person offering its help, along with a flyer stating the union supports this program. Of course, we can only pick out the obvious claims which actually mention mental illness or emotional disturbance. We have to depend on what the doctor writes, and a lot of physicians still don't like to put down a mental illness as the main trouble. They list it as secondary. Or they don't mention it at all. Sometimes, after we've already made payments, we may get an intermediate disability report which is more detailed. Then we can see where these cases, have an emotional basis, we let the health center project know about them.

Industrial machinery was also used to test ways of finding troubled workers before they reached the point of crisis. In this case, a professional from the Project — one of its social workers — did the actual finding, but the union laid the groundwork for him.

Antonio Blanco, M.S.W.
Social Worker
MHRP

We wanted to see what would happen if we just came right to a factory and asked people directly: "Do you have any problems? How do you feel?" Of course, in our industry, the answer usually is, "How should I feel?" (Laughter.) But anyway, Charlie Garrahan, the manager of the Shirtmaker's Joint Board, went along with it and found us a shop where the boss was interested in the idea, too. Chris Bocchicchio, one of the business agents, took me up so I could get to know the people at the factory and they could get to know me as a social worker.

I went up with a questionnaire in three languages — Italian, Spanish and English — that in very simple words asked people to indicate if they were having any physical or mental health problems. To give you an idea of the simplicity of the questions — to reach these people and not scare them off — I'll read some: "Do you or anyone living at

home have any trouble seeing even when you wear glasses?" Or another question, and this is a catching one: "Do you or anyone living at home have a problem with nerves, worries or a mental condition?" Interestingly, out of the 13 people who answered yes to this last question, most crossed off "mental condition" or only circled "nerves."

Altogether 120 people received the questionnaire and we got a 94% return. And then, when I went back to the shop to follow up, it was amazing — people came right over and started talking about their problems. I'll tell you one thing we all learned from this — confidentiality is not a problem with these people. In fact, that was *my* problem at the beginning, because I would feel I had to get the person over to the office to talk. But these people really felt comfortable talking in between the clothing racks. It was only later, after they really began to know me, they felt comfortable enough to come to the office and meet other people — the psychologist or psychiatrist.

This was a method of finding people in trouble and channeling them into treatment that allowed them to move at their own pace. They did move — and a visible measure of their movement was the fact that once the program had been going a while, word-of-mouth brought in referrals to an extent that active in-shop case finding efforts could be reduced.

But clearly, some form of active case finding is an essential first step if this population of workers is to be reached. On that, not only the Mental Health-Rehabilitation Program staff but other mental health professionals at the Conference agreed.

Leopold Caligor, Ph.D.,
William Alanson White Psychiatric Institute

In our clinical service, which is open to the whole community, we found patients who were middle-class or professional people. Over a period of many years, we hadn't seen but two or three blue-collar patients, and we were very concerned about it, especially after we found out this was happening in middle-class clinics everywhere. This was why we started our program with one of the local unions — it just seemed the most direct and

effective way of really reaching workers. It was constantly emphasized that the union was a direct and effective machinery for reaching the mentally ill worker. And through the union workers talked to workers, using words and a common sense approach they understood and by doing so making the alien language and ideas of psychiatry seem not alien at all.

Another union experiment pointed up how the very fact of making these things understandable can be a service to workers. This was a demonstration education program developed by the New York City Central Labor Council for the Taxi Drivers Union, AFL-CIO, whose members — like many other workers who deal with the public directly all day long — have to contend with a special occupational hazard. Added to the physical pressures of their jobs is the insistence of many customers on sharing their problems with the union member, or making him the brunt of their troubled feelings. Accordingly, the taxi union's concern in its project was to help workers learn to cope more effectively with these situations *for their own emotional well-being.*

With this goal, then, arrangements were made with a clinical psychologist to conduct an eight-week course for forty taxicab drivers.

John J. Gehan, M.A.
Job Development Project,
New York City Central Labor Council

What we attempted to do in our program with the Taxi Drivers Union — Local 3036, was to give these workers a better understanding of basic psychological principles. The theory was that there were psychological principles that people who deal directly with the public use on an everyday basis. We let the cab drivers relate how they deal with situations they encountered and what we attempted to do was to bolster their sense of security in meeting disturbing problem situations. We would hope that we could carry this beyond drivers to groups such as bartenders, barbers, retail clerks.

But I have to tell you very briefly one difficulty we had. Unfortunately, the American Psychiatric Association misinterpreted our intent, and in their newsletter they ran an editorial entitled, "A Little Bit of Learning." Since we all know the rest of that line is, "Is a Dangerous Thing," you know they weren't going to write anything flattering. Well, they said that previously when they flew into New York their only problem was getting a cab. Now, they felt, they would

have to be concerned about whether the cab's driver had taken the course so they could benefit from it. Furthermore, they also wanted to know whether cabbies were being trained for long-term psychotherapy as well as short-term, because if they were coming in from Newark, this would be a consideration. (The audience broke up in laughter.)

Actually, I think if they were ever to sit down with us and have it fully explained, they would understand our objective — to combine the common sense of the lay person with an understanding of the professional. We think it can work, and rather well.

("Can you picture," someone commented, "the implications for tipping and salary scales if this ever really gets going!" More laughter.)

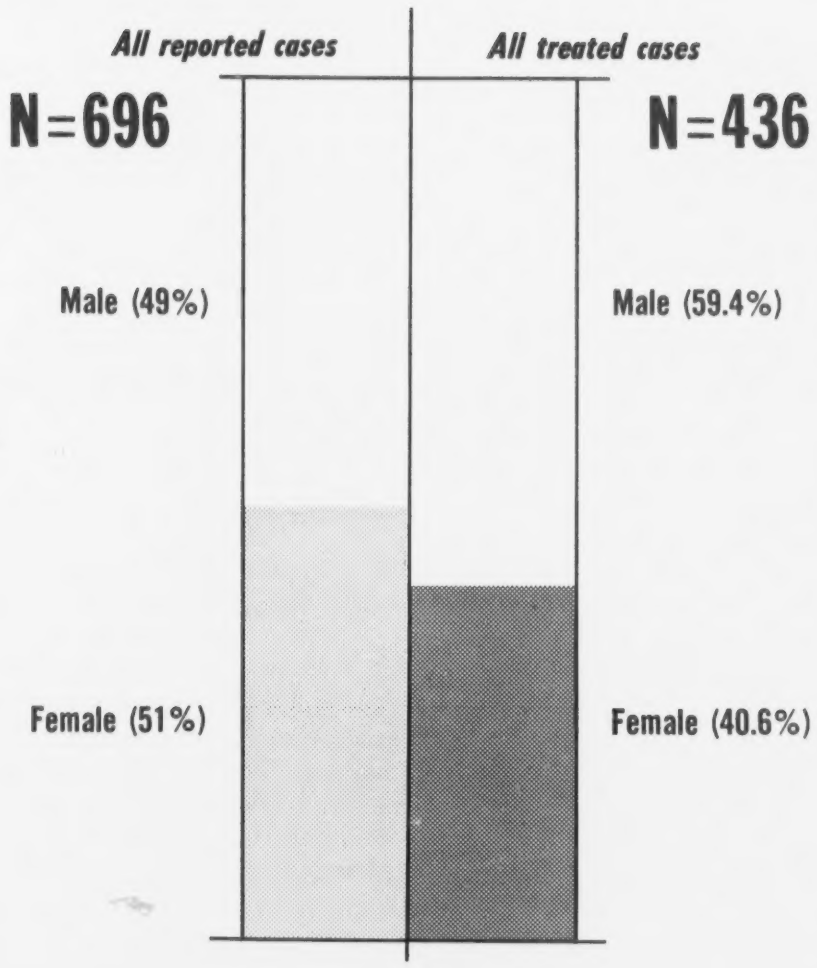
SUMMING UP: FINDING PEOPLE WITH PROBLEMS

Summary charts gave the Conference the figures on how the project located 696 people with mental health problems. The Health Center and the Insurance Fund were numerically the two most important sources of referral (see chart, p. 17), with 32% of all cases referred brought to the project's attention by Health Center physicians. The size of this percentage was attributed to the special efforts and interest of Dr. Morris Brand and his clinic chiefs, and some of the general practitioners and specialists on the staff. The percentage might have been even larger but for the fact — frankly acknowledged — that the project had succeeded only in enlisting the cooperation of a small number of all the Center's staff physicians.

An equally large group of recorded case referrals — 32% — came through the insurance company procedures. The charts also showed that over the entire time period the union had referred 14% of the cases, a percentage which jumped markedly once the business agents became formally involved. It was certainly the union, through the use of its grapevine, which helped bring in another 12.6% of the cases — workers and members of their families who referred themselves.

Over-all, the age distribution (see chart, p. 15) was the same as in the industry's labor force: an adult population with a median age of 47. And it was noted with interest that while half the workers in the industry are male — and while referred cases followed that same 50-50 ratio — more men than women actually were treated (see chart, p. 13).

SEX


All reported cases
All treated cases
N=696
N=436
Male (49%)
Male (59.4%)
Female (51%)
Female (40.6%)

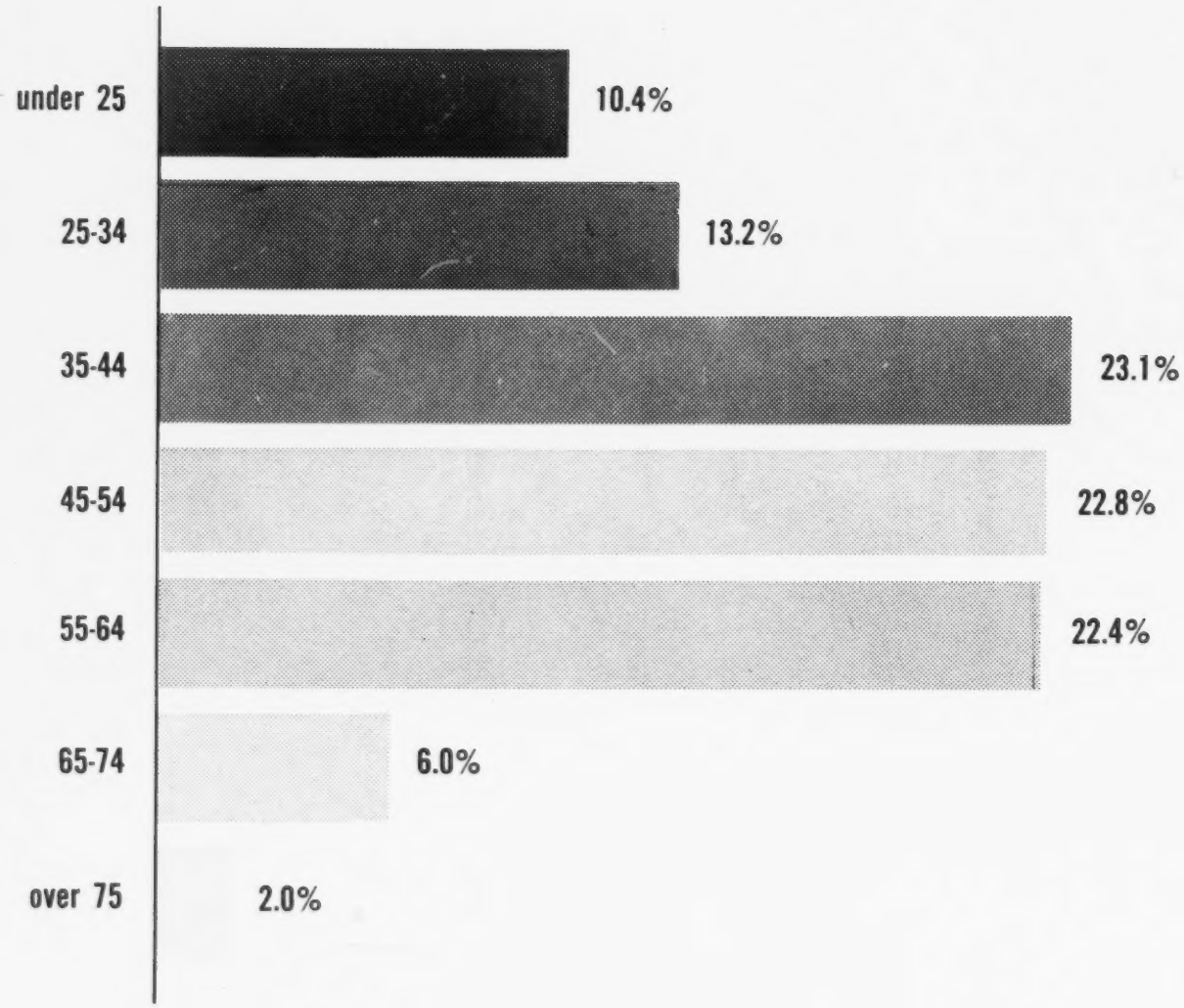
This is quite different from the experience of many mental health clinics and family agencies, and we think it's because of the union relationship. A union guy will talk to a brother in the shop — result . . . a worker who'd never go to an agency gets the confidence to see us and discuss his problems.

Now what else have we learned that we might share with you? Well, the first thing is that finding people with problems doesn't have to start with a formal education program on "What is Mental Illness?" What we've found works most effectively are those activities of the union through which the word-of-mouth can spread. It's what the business agent does in the factories. It's the letters in the union paper, the *Joint Board News*, in which patients freely and publicly thank the union for this kind of help. It's workers getting up at union meetings and telling how they were helped. It's through all these things that the idea of mental health treatment becomes legitimate. It becomes kosher. It doesn't have quite the taboo it had. Other workers don't see the patient as a kook. In fact, I've seen them respect a guy for being willing to face up to his problem — they saw it can take some courage.

The second thing we learned is that just by connecting up the different parts of the existing structure in the industry — by promoting better communication — you get practically a 50% increase in referrals. The insurance fund is doing a good job — with just the simple added administrative procedure of sending over a card about a claim. Though I'd like to see us develop a better follow-up procedure to get more of these cases into treatment. The health center had been paying attention to the area of mental health all along — all we did was play a little bit of a middle-man role. But by doing that — just tapping in to the resources that were already there and bringing them together — we had a consistent increase in the number of reported cases.

AGE

N=696


under 25
10.4%
25-34
13.2%
35-44
23.1%
45-54
22.8%
55-64
22.4%
65-74
6.0%
over 75
2.0%

HOW UNION BACK-UP HELPS IN THE TREATMENT PROCESS

What it does for the worker

If the union link makes it easier to find workers who need help, it also makes it easier for them to accept the idea and to go and get help. And if the first step is important, the business agents attested, the second step is crucial.

Harry Gordon,
Business Agent,
N.Y. Joint Board
ACWA

When this program started and we became active in it, we met with a lot of resistance on the part of some workers. When you spoke about a psychiatrist, they associated it with the crazy house. "You're not going to get me down there and put me in a crazy house!"

We started to get results when we had a shop chairman who needed help — *really* needed it. This was a big factory and everybody knew the shop chairman. They knew what he was going through before he went down to the project, they saw the change in him after — because all the time he was getting treatment, he was working. They really *saw* what happened to the man, and what the rehabilitation program did for him.

So later when a case came up in the shop where a worker was in trouble, the shop knew there was someplace to get help. They told me about the man. He was a very skilled worker, and if the foreman had to return a piece he had worked on, he would sit down and cover his face with his hands and just stay that way until you walked away from him. When I visited the shop, the workers told me to talk to him, but it was the same thing — he would just cover his face and ignore me. Well, it took me about eight months, but finally we got him down to the health center.

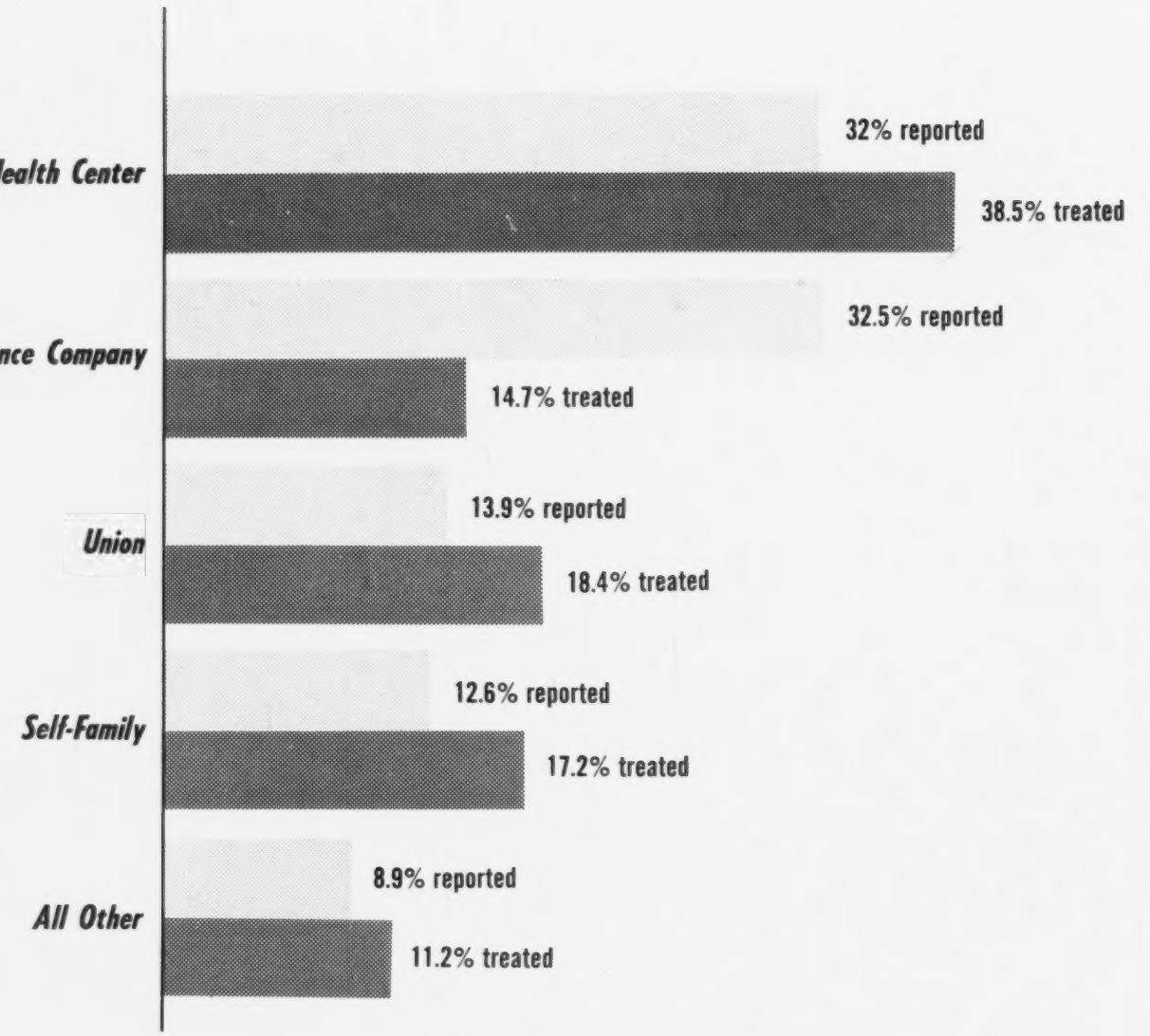
I don't know what kind of treatment they gave him, but I can tell you this — today you can't shut him up!

(Someone in the audience yelled: "Send him back!" and everybody laughed, especially the business agent.)

Another agent agreed.

SOURCE OF REFERRAL

696 reported
436 treated



Lou Goldstein,
Manager,
Cutters Local #4
ACWA

The luck we had with the workers we sent over — I think the reason we've had this success is, with all due respect to the gentlemen in the profession here, we never used the word "psychiatrist."

Instead, what happens is when I find a fellow with a problem, I call him over and say, "I'd like you to talk to the people over at the health center — they're always friendly to our people." And before he has a chance to say yes or no, I pick up the phone and I call Hy or John or Mrs. Esterowitz, and before he knows it, he's on his way to the second floor of the health center. "Go over and see them and come back and see me," I tell him. And we've never had a failure yet on the cases we send over.

You know, when the project first came, I thought only the cutters were the crazy people. Now I know differently. Everybody, in every trade, has problems. But that doesn't make them crazy. And if you don't say "psychiatrist," then they don't have to be afraid you think they are crazy and have to put them in a hospital.

HOW UNION BACK-UP HELPS IN THE TREATMENT PROCESS

What it does for the mental health professional

How, on the other hand, did the project staff feel about the business agent's involvement — the open sharing of responsibility for the patient? How do they react when a business agent walks in with a patient and says, "Get this worker well?" The answer was surprisingly favorable:

Robert Navarre, M.D.,
Clinical Director
MHRP

From my point of view, it's a real advantage when the business agent comes in with a patient, because the patient almost invariably, right from the beginning, takes the trust he already has for the business agent and transfers some of it to me. My experience is that patients have gotten to talking about themselves much more quickly, with less of the natural suspicion of new situations. At the same time, I've gotten so much information about the patient from the business agent that it's much easier for me to

understand the patient's actions. I can decide more quickly what the problem is and how to help it."

In fact, where business agents are not the source of referral, they are often brought in by the mental health professional.

John J. Sommer

When we see a patient at the project, we say, "May we have permission to speak to your business agent or your employer, as well as your family doctor, about your problem?" Three out of four patients give us that permission. The professional crowd may raise the question of confidentiality, of not discussing the case beyond the treatment room, but the workers don't seem to share this concern, at least not in our set-up. So the Professional can go to the business agent and find out what's actually happening on the job — they don't have to go through a long period of give and take with the patient. And this gives us new ways of using the business agent effectively. Not just to locate the patient, but to get feedback and speed up the treatment.

HOW UNION BACK-UP HELPS IN THE TREATMENT PROCESS

What it does to make treatment effective

Once the worker gets to the source of help, and once the mental health professional decides on a course of treatment, the union's role can be even more important.

Harry Gordon

One case I was involved in concerned this middle-aged Italian woman who worked in a factory where I was business agent. All of a sudden during the day, she would start to cry. The factory manager asked the shop chairman whether anything about the job was bothering her. She told the chairman she liked the job, everything was fine — just the same, the chairman brought her to my attention. I went to see her, and she told me the same thing. So all I could say was, "If you need my help, you let me know," and I left.

Well, this went on for about a month — she'd be fine for a few days, then all of a

sudden she would start to cry. The workers around her, would sort of protect her — do her work for her, cover for her if she had to leave the factory — but finally one day she became hysterical and the manager called me up and said, "This can't go on." I said, "Look, you tell her she can't come to work till she comes to see me." So sure enough she came, and I said, "Look, I can only help you if you want me to help you. If you don't, you'll have to find another job." And with that I called John Sommer and said, "This woman wants to be reinstated on her job, but I can't do that unless she speaks to you." And I sent her to the health center.

Well, it turned out the woman had to be hospitalized. I immediately called the factory and told the manager the woman is very sick, and I'll let him know when she's ready to come back to the job. I didn't give him a chance to say this or that, it was just as if she needed an operation or she had pneumonia — she had to go to the hospital. After that, every time I went to the factory, I'd tell them how she's coming along. And at last, the worker herself called me. She was out of the hospital, not quite ready to work yet but just about ready, and she wanted to go visit the factory. So I called the factory and told them that, and I had 100 percent cooperation from the management. Because I kept them informed from the beginning. Because I made them realize that the woman was sick — not a "nut," but sick. This helped keep the job open for her.

Keeping the job open was a unique and vital contribution which the union made. To get the worker back to employment is always rehabilitation's goal, yet the practical fact is that all rehabilitation can really do is get the worker ready to go back. It can't, of itself, guarantee that a job will be there to go back to — the union can.

John J. Sommer

We, as professionals, are never able to accomplish this — to work out a specific plan for a patient's return to a specific job, and in this way ease the way back into the community. Now for the first time, through our

contact with business agents and manufacturers, we know — and the patient knows — there *is* a job there, waiting. We've had a number of experiences where a patient in a hospital program will call the business agent, and the agent will take them to the shop so they can get a feel for it again. And when this happens, the wonderful thing is that they're coming back not as patients, but as *workers,* accompanied by their business agent. Then when they feel ready to work again they just let the agent know.

In other words, what the union does is build, all along the line, a series of bridges that no professional can do by himself — he doesn't have the power, he doesn't have the access. No amount of talk can get him this kind of help — the job guarantee the union can provide, the support it can give in seeing that fellow workers don't give the patient a hard time. And it does make a difference. When you have this kind of arrangement, this openness and trust, you're about three-thousand miles ahead. Because the patient is getting the word from people who count, when he gets it from the business agent, the manufacturer, the other workers. When they say, "We think you are well enough to work," it means as much to him as hearing it from his doctor.

Repeatedly, professionals stressed the range of ways both tangible and intangible in which union back-up services often meant the difference between treatment drop-out and effective therapy.

Robert Navarre

Let's assume I'm treating a blue-collar worker who was embarrassed to come under union auspices and came to me in my private practice. When I see this patient in my office, I have to go through a whole series of talks with him to understand what's going on — whereas if the union contacts had been available for use, as they would be on the project, I could already know a great deal about him. And the next thing is, I have to talk to him in terms of a fee which he can't afford, and I may have to spend a lot of time trying to get him onto a waiting

list at a mental health clinic.

Then let's say I need ancillary help. If he'd come under union auspices, all I'd have to do would be to call the Health Center. I'd say, "This patient seems to have some kind of organic brain disease, I need a quick neurological examination," and I'd have reports back right away — the examination doesn't show anything, the electroencephalogram doesn't show anything — I'd be squared away more rapidly as to the problem. It shortens the length of treatment time to have these services readily available.

Leopold Caligor

It's important, too, that the man in the midst of crisis no longer feels alone. He has the union through which he can mediate. Someone will steer him to psychiatric help, take a friendly interest. This union philosophy of caring has always been the backbone of the labor movement, and I don't know of any place where it operates more effectively than when a worker is emotionally upset and doesn't know how to get help.

Terence Carroll,
Executive Director, National Institute of Rehabilitation & Health Services

When we look at those systems of service which are provided within a union context, and with the re-inforcement a union can provide — and when we contrast them with those systems of services which are provided in a non-union context, without this kind of union assistance — well, I think we can all see the great difference between them. Frankly, I think the system of providing services on a solo basis in the community is operating in a very disorganized fashion. It just doesn't have available anything remotely like the back-up resources psychiatrists or other mental health professionals working in this kind of an organization have — guys like the business agents here, who can really help them accomplish the immediate goal laid out in front of them.

SUMMING UP: HELPING PEOPLE GET TO TREATMENT

Again, summary charts were used to show statistically how many patients received treatment. The overall total was 436 out of the

almost 696 reported cases. Significantly, the union was involved in the treatment program in a great majority of them.

Hyman Weiner

So let me review briefly what we do in terms of helping people accept and get the treatment service they need. The first and most important finding is that the union structure could do things we couldn't to get some of the tougher cases in. Working together, we give each other back-up. So Harry could just pick up the phone and then say, "Go down there and they'll see you now — you won't have to wait and worry."

The second thing we learned is that we had to assign a project staff member — a nurse or a social worker — to sit on top of the case, so the person doesn't get lost between shop or union hall and health center.

Third, the workers had to get to know the helping people at the project. The grapevine had to spread the word that our professionals were people you could talk to and trust; that there was someone who spoke your language — Italian, Yiddish and Spanish.

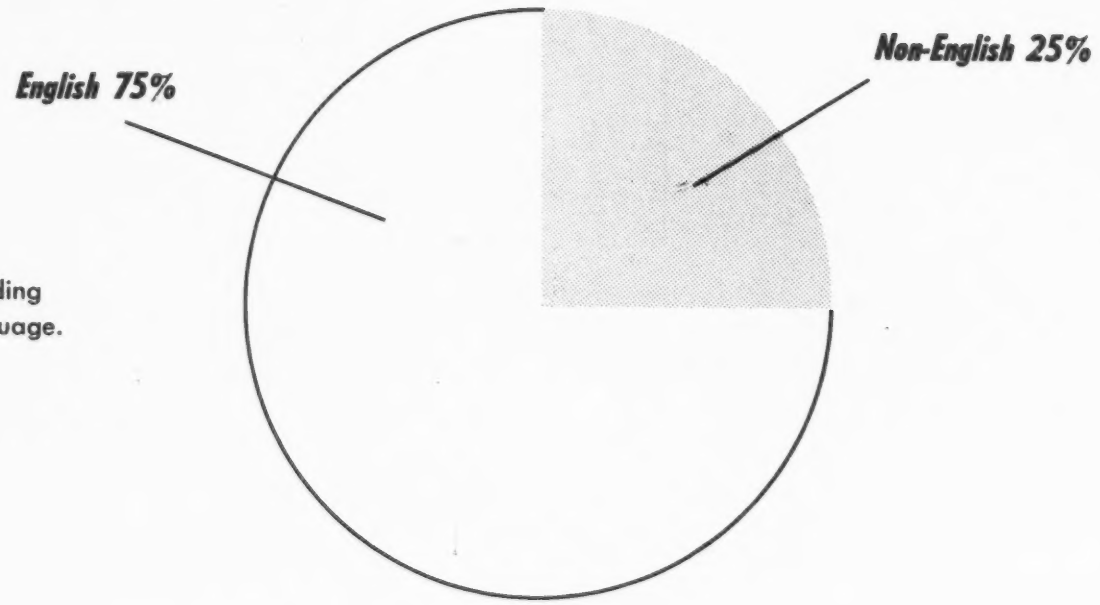
Fourth, it didn't help to pussy foot in confronting a person with his problem. When a person comes in we see him immediately, even if only five minutes is available. We try to identify with the patient, what's bothering him. Treatment starts then and there.

Another lesson we learned is there must be easy access to treatment. You have to be open a couple evenings a week; helpers must be available during lunch hours.

Finally, we found no evidence whatsoever that the patient had to put up cash to get the most out of his treatment. This is one of the most sophisticated gobbledygook ideas the mental health profession ever came up with. We found nothing whatsoever to substantiate that the patient needs to pay. We found that just the pain of the problem was a hell of a motivation to try to get help.

LANGUAGE OF TREATMENT

N=696



Of special help was the fact
that workers began to learn
that therapists were not only understanding
but could understand them in *their* language.
25% of the patients were treated in
a language other than English

HOW UNIONS AND COMMUNITY MENTAL HEALTH FACILITIES CAN TEAM UP

Early in the Conference, it was candidly stated that the Mental Health-Rehabilitation program was being presented as one possible model for a union setting. So the Conference listened with particular interest to the experiences of other unions.

Local 259 of the United Automobile Workers, AFL-CIO, has developed a mental health program with the William Alanson White Psychoanalytic Institute. The Conference heard what the program meant:

Samuel Meyers,
President, Local 259, United Auto Workers, AFL-CIO

Once upon a time — and it's still true for locals that don't have mental health programs — a cause for discharge was bizarre action, or even less than bizarre action. Somebody's absent, nobody tries to find out why, and the worker's fired. But now that we have a mental health program, this is no longer the case. Now we can say to the employer, "This worker seems to have a mental problem and before you fire him, we want to try to do something about it."

Sure we've had cases where workers will shy away from going to the William Alanson White Institute. But then we confront him with an either/or proposition — either go for help, or get fired — and invariably the person will go. Which shows, among other things, that you *can* initiate motivation — and though I know this runs a little counter to what the mental health people tell us, that a person must go on his own free will, it works for us.

Another thing different from what we've always heard is that we found, too, that services can be free for the patient. Our members don't pay any money directly to the analyst or psychiatrist, and we have tremendous utilization.

And certainly one of the most interesting and important things we learned from our program is that it didn't just do something for our members, it did something for us in the process. Don't let anyone kid you, it's a two-way street. *We* develop new dimensions.

SAM MEYERS, *President, Local 259, United Auto Workers*

"Somebody's absent, nobody tries to find out why, and the worker's fired. But now that we have a mental health program, this is no longer the case."

We develop sensitivities we never had before. *We* begin to look into the lives of other people in depth, rather than settle for superficialities.

But over and above the new respect that the member gets for his union, or the leaders for the membership — there's an additional insight that's developed. This has to do with the practicing psychiatrist vis-a-vis this special population. Most psychiatrists who practice have little orientation to the working class. We were very fortunate with the Institute to have staff who sympathized with this new population, even though they hadn't worked with them before. Who were able to admit that when there's a drop-out or a failure, the onus isn't always with the patient — it might be with the psychiatrist. In short, we were able to shape a relationship among union leadership, the White Institute and members that's been enormously successful.

Now the fact that we are succeeding in our local union is hardly the issue here. We belive that what we've learned, the experiences we've had, must be shared throughout the labor movement. It seems to me there are enough programs now for us to get a pretty accurate picture of how much does it cost. And when we've got that, we can begin to talk about how all the members of the labor movement can have access to this aspect of health, just as they have access to all other aspects of health. I don't know whether this Conference alone will be able to determine what structures should be developed. But if there's anything we can do in sharing our experience and working with all the labor leaders who're here today — well, we're very willing. Because we must broaden the too few programs we have at present in the area of mental health.

The Mental Health-Rehabilitation Program itself had also looked into the community for certain services for its patients. This was done not only because the project couldn't do the entire job by itself, but out of a desire to see what relationships could be developed between labor unions

and hospital clinics which would be mutually helpful — most of all, to patients.

The chief outside services required by the project were two. First, because the Sidney Hillman Health Center was exclusively an outpatient facility, in-hospital resources were needed. Second, because the Center project's focus was limited to vocational problems, project staff had to be able to call on others to provide services for workers and their families having other kinds of emotional difficulties. Accordingly, contracts were made with three hospitals: Mt. Sinai, St. Vincent's, and Maimonides.

In the arrangement with Mt. Sinai, one of their staff psychiatrists was assigned to work at the health center part-time in a liaison capacity. His job was to run cover for union members referred to the hospital — to help get them admitted; to see that, once there, they didn't get lost in the administrative shuffle; and to work with the project on getting them back to work. He was asked to describe the experience.

Burton Nackenson, M.D.,
Psychiatrist,
Mt. Sinai Hospital

I think that in terms of rehabilitating patients, one of the greatest assets we have at Mt. Sinai Hospital is that we serve the best chicken soup in New York City.

I'm not kidding. There's a word in Jewish, "heimische," that means something very real and important in treatment — a homey feeling, a quality of caring. And because this is one of the feelings the union has been able to communicate to its members, it's made treatment easier for every professional involved in this program. Previously, in dealing with individuals without these resources, we hadn't been able to make any real headway, which is why I look on this program as such a profound experience.

St. Vincent's Hospital made no claims for its chicken soup, but one of its psychiatrists commented in the same vein:

Edward Hanin, M.D.,
Assistant Director,
Outpatient Clinic,
Department of
Psychiatry,
St. Vincent's Hospital

We've been working with the Sidney Hillman Health Center for about two and a half years. I'd like to echo the comment that there's something about the patients who come to us from the Center that makes psychiatric treatment much easier. There's the feeling on the part of the patients that people are interested in them — that they have jobs to go back to — that their concerns

BURTON NACKENSON, M.D., *Mt. Sinai Hospital*

"a quality of caring. And because this is one of the feelings the union has been able to communicate to its members, it's made treatment easier for every professional involved in this program."

are being dealt with on two levels: on the level of the mental health profession, and on the union level.
Essentially, we have run into no problems. We've had our successes; we've had our failures; we've certainly had our experiences. But despite the fact that there's been no screening, no selection by us at all of which patients we'll accept, the patients who've come through the program have, in general, done extremely well.

There's also another angle to the program which is tremendously important to us since we're a training center as well as a hospital. This liaison has helped us acquaint our doctors and our whole professional staff with the labor population and workers' problems.

Psychiatrists have a reputation of remaining pretty much in their office, not being terribly aware of what goes on outside, and I think this has been a justifiable criticism. This program, from our point of view, has been extremely beneficial in terms of breaking down some of our own barriers and misconceptions — we're extremely happy.

HOW TREATMENT CAN BE TAILORED TO WORKERS' NEEDS

There was no question in anyone's mind at the Conference that one of a worker's most basic needs is to work. To stay on the job, even though mental problems may be making life difficult. To get back on the job, if his problems have made working impossible. What kind of treatment program can best accomplish these goals?

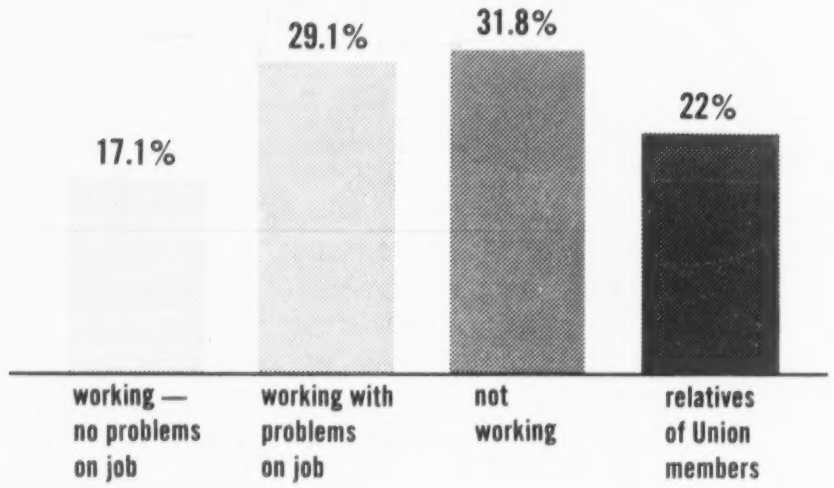
The Conference wasn't intended to provide a definitive answer, and it didn't propose to engage in a debate on the relative value of various techniques of psychotherapy. What it did provide was an arena for discussing what actually happened in some specific kinds of treatment used by a variety of projects. Without attempting to define what form therapy should take, it reported on forms it had taken. And asked only: Which ones work — and why? And how long did they take?

But first, the Mental Health-Rehabilitation Program presented its findings on the characteristics of workers in a mental health treatment program.

WORK STATUS

at time treatment begins

N=436



At the time they entered treatment, only 17% of the 436 patients were working with problems not directly related to the job (see chart, p. 31). Over 60% of the patients had work-connected problems. They needed help to be able to maintain themselves on the job or return to work. The rest — 22% — were retired, or relatives of union members. So much for work status.

You can also categorize them another way, and in this way, we see the patients we've treated so far as falling roughly into three groups. The first kind is the sick guy you can help over the hump in a short time, but you know he's going to be back in a few months with another acute problem. Just like the person with a chronic condition like arthritis or a coronary — there are periodic flare-ups or attacks, there's a rhythm to it, it's spread out. The second type is the patient you help over the hump, like a sudden upsetting death in the family. He pulls out of it, and you have every reason to believe he's going to continue functioning in a healthy way, coping with the normal problems we all have. Then we have the third group. They need sustained help — at the beginning, middle and perhaps forever.

And please note that for none of these groups do we use the word "cure." All we aim for is to alleviate the symptoms enough to keep the patient on the job.

Treatment offered by the Mental Health-Rehabilitation Program consisted, for the most part, of individual sessions tailored both in time and approach to the worker's world. A session might be a conventional 50-minute hour in the evening, or 15 minutes during a lunch break, or ten minutes on the telephone. In it the therapist would be direct: "What is it," he would ask the patient squarely, "that's getting between you and getting back to work?"

Some patients were channeled into group treatment. The group approach has been used successfully by many agencies, but the project wanted to introduce some experimental variations in the process, focussed on its rehabilitation goals.

Jaime Titievsky, M.D.,
Psychiatrist
MHRP

We began the program of group therapy early in 1966. We wanted to test different methods of treatment.

We had such good results with the first group that we began a second group with a more specific selection criterion. That is, this time we limited it to persons who had work-connected mental health problems, but who weren't working at that point. We thought it might be helpful to put this kind of a group together and start a dialogue around specific work situations, such as how you deal with a foreman. We hoped that this way, we'd get some honest talk — very real talk that's often hard to draw out individually, and that this would facilitate their returning to work. What I found, very early in the group process, was that the feeling of trust developed to a greater extent than in other groups I'd participated in outside of the union. The members began to trust us and talk very freely about their problems.

And we saw how one person who's willing to return to work can push another member who thinks he isn't ready to return, with the result that the second person might begin to progress a little quicker than otherwise.

We also tried to test how the members of the group could be utilized to help the treatment termination process. This is a process we, as psychiatrists, get very concerned about, because we don't want to discharge patients until we know for sure all the problems are pretty much cleared up. But here we tested letting the patients suggest when it was time to terminate, and up to this point I must say we've had very good results. We have found that group members aren't afraid to bring about termination.

That a realistic approach to emotional problems is characteristic of blue-collar workers, was borne out by other psychiatrists.

Leopold Caligor

I think the blue-collar patient comes to therapy with different expectations than does the middle-class patient. Most of the blue-collar patients we see come in a state of

crisis. Their world is falling apart — they're no longer on top of it. What they want is to get rid of this new unbearable anxiety and get back to where they were before the crisis, so that they can continue their usual way of life. Typically, when the blue-collar person comes in, it's like going to a dentist. He wants to get at what bothers him and get beyond it — alleviate the crisis. And it's surprising how in sixteen sessions or less, 80% of our patients do manage to obtain relief. This doesn't mean that problems may not show up again at some time in the future — but then, even if they do, it may be enough just to come in for an hour or two of therapy. It seems to me this is a very economical way for a professional to spend his time.

It has been our experience that as middle-class therapists develop know-how with this kind of patient — that is, using analytic insights, but applying them in new ways — therapy becomes shorter, more effective. I think professionals have a lot to learn in this area.

A reporter on the *New York Times* asked whether what had been learned from short-term treatment of blue-collar workers couldn't be applied as well to white-collar patients who often spend years in expensive psychoanalysis. There was a wide range of response.

Sadie Zaidens, M.D.,
Psychiatrist
SHHC

I've done group therapy with the Mental Health-Rehabilitation Project — I've also done therapy with so-called white-collar class patients in my office. And frankly it amazed me, the speed with which people of the Amalgamated Union were able to gain insight into one another's problems and into their own problems.

It seems to be that the higher the level of education, the more rationalization there is. The sophistication of the more highly educated keeps them from really facing their problems. One just doesn't get that kind of rationalization and resistance in the blue-collar class. Workers can see things in the raw sometimes within one or two sessions. Certainly they can see it in one another —

and they're much freer in discussing these problems with one another.

The possibility was raised that the significant distinction was really not between "white-collar" and "blue-collar," but between short-term and long-term approaches to treatment.

Gertrude Neary, *New Jersey Rehabilitation Commission*

I am wondering if this short-term treatment can really be compared with the "white-collar worker's" years of analysis. This appears to be treatment to help meet an immediate crisis — while the "white-collar worker's" analysis supposedly develops insights that will change his whole pattern of behavior. I am interested in why you have such quick results and whether they are at all lasting in their effectiveness. Is it reasonable to assume that the "white-collar worker" may be better able, on the long-term basis, to cope with crises at any later point in his life? I'd appreciate if the doctors would comment.

Interestingly, it was not the doctors, but the union men who responded.

Sam Meyers

I see it this way. The white-collar worker has goals, but they're more undefined. The blue-collar worker has an immediate goal, to get back to work. If he's in a crisis and he's a working man, he just wants to get back and make a living as soon as he possibly can. If he feels ill some other time, if the same symptoms arise or others — well, then you can deal with that problem just as fast, because work is still his immediate and practical goal. Of course, this is from our point of view as a union, because we see it all the time.

Sam Shniter

I would like to make a comment to the lady. It's being talked here about the statistics — so many people under care for a long time, so many people under care for a short time. But we shouldn't forget this one thing — that when a person is sick, this involves a family. So when we approach the cases, it's to bring back both the person and the whole family to have a good financial standard. And if we can bring back one or two people out of a hundred — bring him back not

100% cured, but bring him back so he could be able to work and support his family, I think this is a great accomplishment and our whole object as union people.

SUMMING UP: ASPECTS OF TREATMENT

The summary charts for the Mental Health-Rehabilitation Project showed that most patients were helped in a very short period of time. Only 19% were in treatment for more than six months. Twenty-three percent took from three to six months, 11% two to three months — and 31% were helped in less than one month. The biggest cluster of patients finished treatment in three months or less (see chart, p. 37).

Hyman Weiner

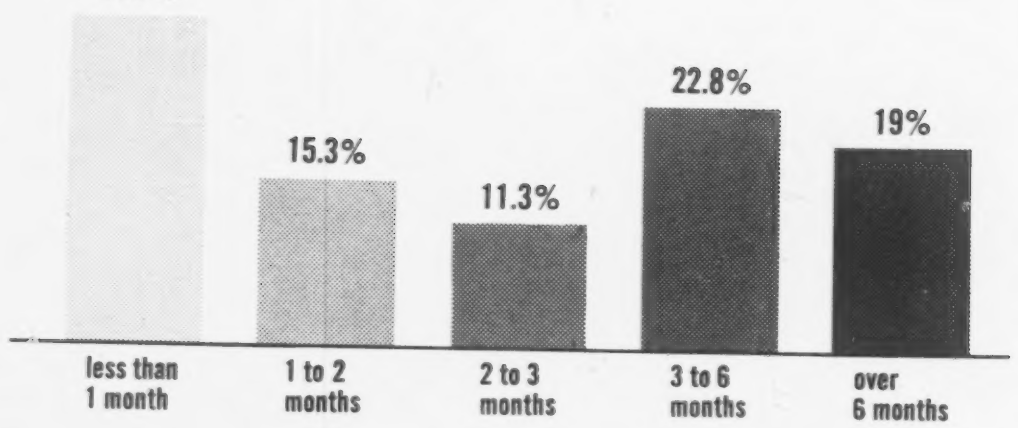
Again, I want to say that in no way can we say that these persons are cured. When we say we "helped" a person we mean it in the military sense — we got him back to the front line.

In terms of the number of interviews, the biggest group had four interviews or less — face-to-face interviews, that is because there was a considerable amount of telephone contact. Still, looking at the cumulative figures (see chart, p. 38), 57% of the people were helped within four interviews. This sounds ridiculous, I know. Well, it can be done, if you say, "What's the problem on the job, buddy? Where's it pinching?" Sure, some of these people could use long-term therapy, but that wasn't our primary focus in this particular project. Of course, some people will continue to need help even when they get back on the job. But with the machinery we've set up, this help is no further away than the nearest telephone — call the business agent — call the project.

One of the biggest problems we had, as professionals, was to let the union guys in on treatment. Send us the cases, we said at first — we'll fix them up and send them back to the job. Actually, I think we were a little scared. Many mental health professionals feel you shouldn't make public the inside secrets, the little magic, the bag of tricks. But it couldn't work like that here. We had

LENGTH OF TREATMENT

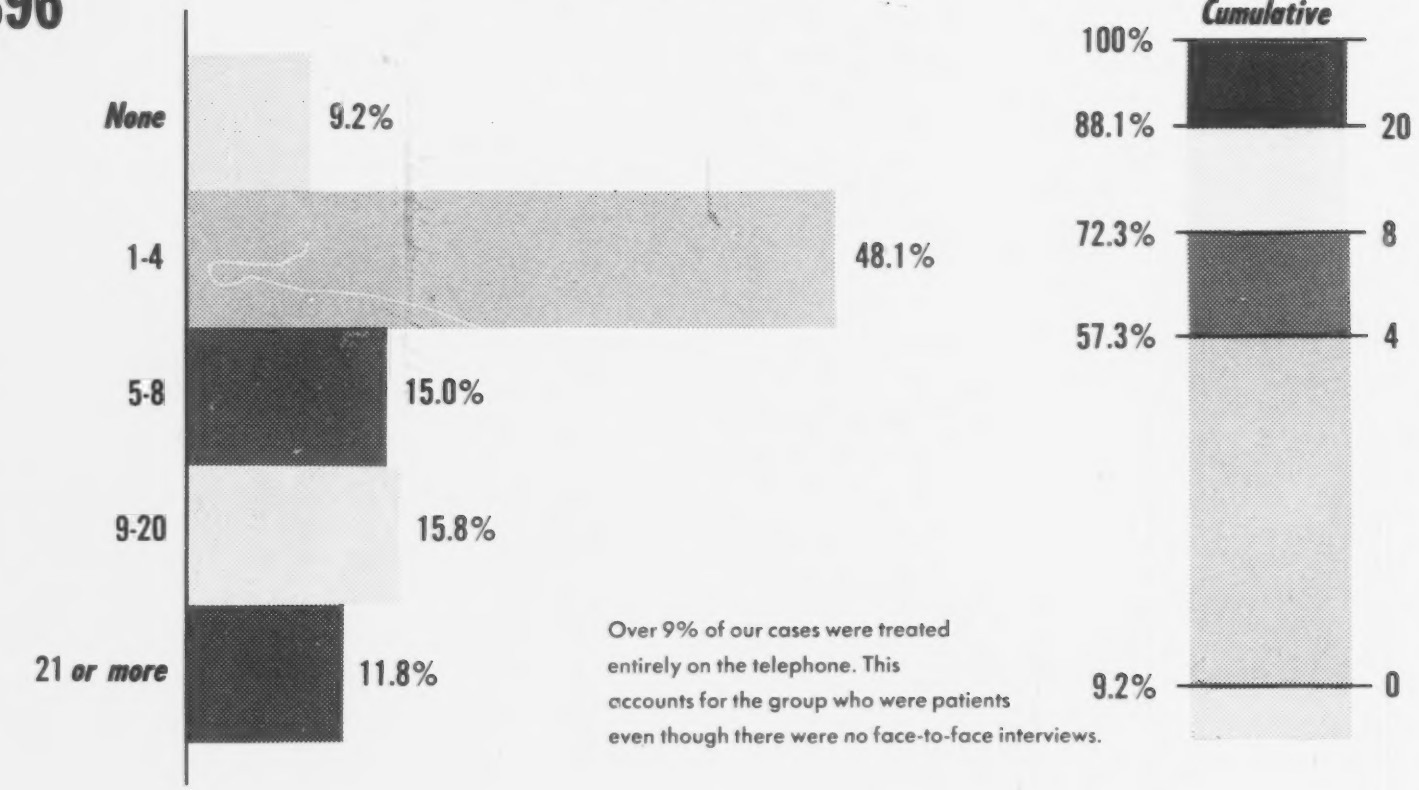
N=396



NUMBER OF FACE-TO-FACE INTERVIEWS

with patients...

N=396



Over 9% of our cases were treated entirely on the telephone. This accounts for the group who were patients even though there were no face-to-face interviews.

to begin to trust each other and to share. Now when a case comes in, we move in with the union and work together much quicker. These are some of the insights we have gained which have given us encouragement. And a program like this can work, if you're willing to settle for modest goals. And if the mental health people and the union people consent to trust each other, let alone having the patient trust both of us.

WHAT DOES ALL THIS IMPLY FOR LABOR, GOVERNMENT AND COMMUNITY MENTAL HEALTH PROGRAMS?

A congenial luncheon — with no dais table — reflected the unanimous sense of the meeting that mental health services for workers are a matter of equal concern to all three of the interested groups represented by Conference participants. The afternoon session which followed openly aired the problems of implementing this viewpoint. Candid cross-discussion probed issues involved in developing each group's roles and responsibilities — issues as touchy as they are new, as tough as they are important.

LABOR AND MENTAL HEALTH: *Some comments by government officials*

Government representatives applauded what they regarded as evidence of labor's new interest and involvement in the mental health issue.

Salvatore G. DiMichael, Ph.D., *Assistant Commissioner, Region II, Vocational Rehabilitation Administration:*

If what lies ahead of us in mental health rehabilitation seems big, seems fairly impossible, I suggest we look at the distance we've covered. Here we have a wonderful illustration of the fact that labor unions — once regarded as indifferent, unconcerned and possibly even antagonistic to disabled people, — are, in fact, not so. Here we have the living testimony. If this doesn't give us a sense of confidence in what we can do, then something's wrong.

And I can tell you this: The Federal Government is as much interested in this as you are. The Federal Government has seen in the Amalgamated Mental Health-Rehabilitation program a positive experiment that has worked out. The biggest message we can bring around the country is the message we've been privileged to hear today. Each of us has a mission, has a responsibility, to translate this conviction into action throughout our other unions and throughout our other social organisms. We've got to make this live.

From left to right . . . VINCENT LACAPRIA, *Vice President, S.H.H.C.* —
CHARLES J. GARRAHAN, *Chairman, Shirtmaker's Joint Board, ACWA* —
HYMAN WEINER, *Director, Rehabilitation-Mental Health Program, S.H.H.C.* —
The Hon. LOUIS L. LEVINE, *Deputy Commissioner, New York State Dept. of Labor* —
MICHAEL SAMPSON, *Chairman Community Services Activities, N.Y.C. Central Labor Council, AFL-CIO*
SAM MEYERS, *President, Local 259, United Auto Workers* —
MORRIS BRAND, M.D., *Medical Director, S.H.H.C.*

"The Federal Government has seen
the Amalgamated Mental Health-Rehabilitation Program
a positive experiment that has worked out."

Simon Auster, M.D., *Psychiatris', consultant on occupational psychiatry to the National Institute of Mental Health:*

Those of us who had the opportunity to review the Mental Health-Rehabilitation Project's original grant application were most impressed by the thoughtfulness that went into it. And impressed by the project's awareness of the new trends in mental health care — its reflection, particularly, of a special concern with enabling the individual to deal with the daily problems central to all our lives, such as work and maintaining a position in one's family and community.

We also felt it was highly significant that a union was supporting this project, and was concerned with trying to develop these ideas which, at that time were — they are even now, in fact — still very new and only beginning to be appreciated by the community at large.

Mildred Arrill, *Chief, Program Analyst, National Institute of Mental Health:*

The NIMH became involved with the Sidney Hillman Health Center program because we thought it was important to look at some of the possible roles of a labor union vis-a-vis mental health service for its members. This project has now shown NIMH that within the kinds of arrangements that were worked out here with the support of the union, management and all the systems feeding into this particular project, it *is* possible to keep people going — people who, two years ago, would have had to cost the community, their families and the government a great deal of money because they wouldn't be working. We have proved, by setting up all these interlocking systems, that a man or a woman with emotional problems can work.

And I think the implications of this project are very, very wide.

DEFINITION OF COMMUNITY:

A search for Labor's role

The question was posed as to the role of the union in the emerging community mental health movement. The issue was defined:

Hyman Weiner:

NIMH has put down a very sound proposition — to get a geographic location and saturate an area with services — day hospitals, night hospitals and so on. That's a fine notion, but we believe it isn't the only way to set it up — there's room for a more flexible interpretation in addition to geographical saturation.

Simon Auster, M.D.:

The Federal Government is supporting, throughout the country, mental health centers whose goal is to provide comprehensive care to a community. The broader view which the Mental Health-Rehabilitation Project reflected — the emphasis not only on an individual's personal sense of well-being but also on his productivity as a member of the community — this is also the main theory and thinking behind the current federal support of these centers. It's through this route that we think this program should be able to be replicated in other areas.

As well as direct treatment, these centers are obligated by law to provide a liaison — consultation services. Through these services — this liaison which could be provided to unions and their staffs, the relationship can be developed that will enable the worker's sense of trust in his union to be transferred to the mental health professional, as this project has shown to be so helpful.

Now, it's important that these centers get sufficient community support, because federal funds must be matched by local community funds and this is an area where, again, the union can be effective. I hope that as the unions become more acquainted with the programs in these centers, relationships will be established with them. This is where you will get your support from the government.

Some seemed to opt for broadening the geographic definition to include other types of organizations.

Terence Carroll:

I wish that the folks who developed the rules and regulations for application to the Community Mental Health Act had used the term the Commission on Community Health has used in talking about areas of service. They used the term "community of solution" because they recognized that geographic communities aren't always the most effective divisions. I see no reason why a "community of solution" can't be the members of a union, the members of a fraternal organization, or the students of a university, college or even high school.

I would encourage both organized labor and the people who are in a position to influence the development of our public programs to think in terms of how we can use the organizations to which we belong, the communities in which we live, the social systems in which we function — how we can use these to do a better job for our people.

What I am saying is that there is some shortcoming here in not recognizing that a number of people have different roads to Rome — that we could use both a geographic area and a "community of solution" as a basis for the definition of the population to be served.

Mildred Arrill:

What the mental health center becomes in any community depends on how angry and how eager you union people are to get involved in working with them to develop services — how early you get in on the planning and what you ask for. Suppose another labor union was interested in developing services similar to the Sidney Hillman Health Center project, but didn't have the mental health staff. Why couldn't the labor people sit down with the professionals at the community mental health center and say, "you have 'x' number of union members in this community. This is the kind of service we'd like to work out with you." Maybe in the community, the union could be the referral agent, and the center could have a mental health team that would concentrate on serving the labor unions.

If you think you need specialized services for labor unions, well, participate in the development of those services. And get yourself the kind of funding — either through public insurance or through the various private insurance plans — to make sure your members have the kind of coverage they need, so they can go to the centers and say with dignity, "I'm entitled to this kind of service."

Hyman Weiner:

We believe the labor movement has to get into the community mental health game in a way they haven't been before, and not only around the money questions. The concrete is being poured, and some of that concrete will be poured right over some creative services. Well-meaning people at community mental health facilities will by-pass, with all the best intentions in the world, the needs of many working people in their area.

So I believe the labor movement has to become involved right now — today — in how these community mental health programs are going to be shaped. And if they do, I think the entire community mental health program in New York will benefit.

TOWARD NEW PATTERNS OF PUBLIC-PRIVATE RELATIONSHIPS: *Financing and other dilemmas*

The problem of lack of funds to back up the leadership and organizational contribution of labor was posed by a leading representative of the New York City labor movement.

Michael Sampson, *Chairman, Community Services Activities, N.Y.C. Central Labor Council:*

At the time we initiated our Central Labor Council rehabilitation demonstration, our thoughts were directed towards physical rehabilitation. But as we got deeper in, there was no area of trying to help an unfortunate person that we didn't get involved in, and in the little over four years the project has been in operation, processing over 4,000 cases, our statistics show that 60 percent of these cases were re-employable.

Now in our final year, we are faced with a dilemma. The government and the union together have spent almost $800,000 in laying the foundation of a project that's proven itself worthwhile. Can we invest this kind of money and let it go down the drain?

The expectation seems to be that labor should pick up the cost of carrying on successful demonstration projects like this, when the fact is that it's financially impossible to do so. Contrary to a lot of people's ideas, labor doesn't have unlimited funds. Eighty percent of the affiliate locals in the New York City Central Labor Council belong to small unions that have no welfare funds. A large number of them don't even have the funds to pay for full-time officers. Even the larger unions that do have welfare funds are limited by rules that say they can't make a contribution to such a project even if they wanted to.

So if all these efforts of four, five years aren't going to be lost, what's the answer? The answer is proper financial assistance from the government to carry on the good that these projects do for the community.

The need for labor to continue its efforts in mental health was supported by everyone. The question of finding the financial resources to guarantee continued participation was explored. Various speakers promoted government, management, insurance companies and labor itself as the favored solution.

Mildred Arrill:

What we in the Federal Government can do is determined by what the people you elect give us the mandate to do, the legislation to do, the money to do. Right now there is no mandate and there is no money for the continued support of mental health services to labor union populations.

If the labor unions decide they want these services, some unions can use their health and welfare funds. Some, such as the UAW, go in for collective bargaining arrangements. Others work out other ways. But there are ways.

MICHAEL SAMPSON, *Chairman, Community Services Activities, N.Y.C. Central Labor Council, AFL-CIO*

"Contrary to a lot of people's ideas, labor doesn't have unlimited funds."

If you want these things, you and not the Federal Government are going to have to go out and beat the bushes. What we are ready to offer you is consultation, assistance, money for demonstration and research projects, and the opportunity to spread around the country word of the good things you accomplish.

Louis Levine, *Deputy Commissioner of Labor, Department of Labor, State of New York:*

I think we have to look at the core of the problem. Government has a responsibility today because we've seen the failure, over the years, of the private sector and the voluntary sector to meet the needs of our people. Government has had to move in, and government will have to continue to support all facets of our community — and the labor movement is a social movement that must be supported on the same level as social agencies.

I think it's wrong for government administrators to take the easy way out, and fall back on the fact that legislation is so constructed that we can't move. We need more people on every level of government who're willing to say, "Yes, the legislation is restrictive, but let's see how we can maneuver within it. And if we can't, then let's call that to the attention of the legislators because we can make recommendations, too." Don't fall back all the time on pressure groups — on labor and consumers. We have responsibility in government, too.

At the same time, labor also has responsibliities. I subscribe to some of the things that have been said about labor not having the money to continue these projects. There is some money — for example, in the welfare funds. We must have, right now, a commitment from union pension and welfare fund administrators that they will assist programs like these. That theirs isn't just an insurance endeavor, but a social endeavor on behalf of all the union members.

I think there has to be a melding of union and government support. It will be wrong for the Federal or State Government to withdraw funding, but it will be just as wrong for labor to say, "We will be completely dependent on the government."

Howard Hess, M.D., *Consultant,* New York Times
How about some support from management?

I worked as a psychiatrist at the Hillman project during its first year and then went to work with the *New York Times* as their staff psychiatrist. In my first four or five months at the project, I heard very little from management. Then when I went to the *Times,* the situation was turned around — you work with man-

agement, and you begin to forget there is a union. What I'm trying to say is that no one today has mentioned both sides of it. While this is very much a union problem, it's also a management problem. The idea of a "company doctor" can't exist as it does now. There's no reason why he can't be paid by both labor and management —- or why projects like this couldn't be supported by both.

Donald Rubin, *Joint Retirement Fund, Pocketbook and Novelty Workers Union:*

Every voluntary insurance company in the New York City area discriminates against mental illness. Blue Cross will provide coverage in a general hospital for mental illness, but it's almost impossible to get a Blue Cross bed for someone who is suicidal or depressed. There is at least an 8 to 10 week wait for a psychiatric bed. I think what we have to do is convince these quasi-public insurance companies to provide psychiatric coverage in their programs.

The State AFL-CIO favors legislation which would mandate equal benefit for mental and physical illness. If Blue Cross won't change these contracts voluntarily, we should support legislation requiring them to cover mental illness in psychiatric hospitals.

Bruce Grynbaum, M.D., *Director of Physical Medicine and Rehabilitation, Bellevue Hospital:*

I think that rather than count on a long-range plan that may take some time, you should put adequate pressure now on Blue Cross and Blue Shield through labor representation on their Boards. You've demonstrated that a good number of immediate problems can be covered at comparatively small expense — after all, about 35 to 40 percent of your cases were short-term cases. I think immediate attention should be given to the already established institutions in the community, to get them to provide coverage for this problem.

Sam Meyers:

Knowing something about the labor movement, before I'd condemn the quasi-public insurance companies, I submit that if the labor movement took as much interest in mental health as it did in all other aspects of health, these insurance companies would get off their backsides and do something for us. Let the labor movement get together and adopt mental health as one of its primary goals, and everbody will get into the act.

The social agencies, the community health programs — they're going to look to us for money. If that's going to be the case, we want to start off from the very beginning, from the planning.

We don't want to leave it up to the professionals. We believe we have enough intelligence in our own midst to give it to the professionals as the professionals expect to give it to us. So I suggest a continuation so that we can come up with answers that will serve the community — the labor movement in a partnership with the Federal Government, the employers, ourselves, in a total assessment of the entire community's needs.

After endorsing Sam Meyers' proposal, the chairman closed the meeting.

Morris Brand, M.D.:

We are here today to exchange experiences and ideas on a subject that is very important to us because it is important to the members of our respective unions. We were here today not to blow our own horn, that is, the one we have at the Sidney Hillman Health Center, but in keeping with the season, to blow a shofar, to break down the barriers and the walls which have made it impossible, too many times, for workers to get care for their mental health needs. And you'll be hearing from us as progress is being made.

Should the reader require further information regarding the labor mental health services reported herein, please feel free to contact the Mental Health-Rehabilitation Project, Sidney Hillman Health Center, 16 E. 16th Street, New York, N. Y. 10003.

Project Staff*

Shelley Akabas, M.B.A.	*Research Director*
Antonio Blanco, M.S.W.	*Psychiatric Social Worker*
Edna Coleman, M.A.	*Administrator*
Ruth Esterowitz, M.S.W.	*Social Worker*
Bruce Grynbaum, M.D.	*Medical Co-ordinator*
Rose Lewis, B.A.	*Research Assistant*
Burton Nackenson, M.D.	*Psychiatrist, Mt. Sinai Hosp. liaison to project*
Robert Navarre, M.D.	*Clinical Director*
Yetta Ostrow	*Secretary*
Elda C. Patton, M.D.	*Psychiatrist*
John J. Sommer, M.S.S.	*Co-Director*
Jaime Titievsky, M.D.	*Psychiatrist*
Nilsa Velez	*Secretary*
Hyman J. Weiner, D.S.W.	*Project Director*

* *Listed alphabetically*

WHO CAME?

The Conference was held on an unusually sunny Saturday, September 23, 1967, at the Commodore Hotel in New York City. It wasn't an open conference; invitations had been sent only to a small selection of interested organizations.

Nevertheless, 120 participants came.* From labor, from the mental health community, from concerned government agencies.

Shelley Akabas, M.B.A.	*Mental Health-Rehabilitation Program, Sidney Hillman Health Center*
Anne Altman	*New York State Employment Service*
Mildred Arrill	*National Institute of Mental Health, Department of H.E.W.*
Max Asherman	*Amalgamated Clothing Workers of America, New York Joint Board*
Simon Auster, M.D.	*National Institute of Mental Health Department of H.E.W.*
Roberta Barnette, A.M., R.N.	*New York City Central Labor Council, Labor Rehabilitation Project, AFL-CIO*
Margaret Barry	*New York City Central Labor Council, Labor Rehabilitation Project, AFL-CIO*
Burt Beck	*Editor,* Advance, *Amalgamated Clothing Workers of America*
Isidore Beiner	*Amalgamated Clothing Workers of America, New York Joint Board*
Antonio Blanco, M.S.W.	*Mental Health-Rehabilitation Program, Sidney Hillman Health Center*
Anne L. Boland	*Social Service Department, St. Vincent's Hospital*
William H. Bowe	*New York City Central Labor Council, AFL-CIO*
Robert A. Brady	*Associated Hospital Service*

* *Listed alphabetically*

Morris Brand, M.D.	*Sidney Hillman Health Center*
Rolf Buchner	*Communications Workers of America*
John Burnell	*New York City Central Labor Council, AFL-CIO*
Dorothy Cadet	*Office of Economic Opportunity Training Program*
Leopold Caligor, Ph.D.	*William A. White Psychoanalytic Institute*
Terence Carroll	*National Institute of Rehabilitation & Health Services*
Sam Cimaglia	*Buliding Service Employees International Union*
Edna Coleman, M.A.	*Mental Health-Rehabilitation Program, Sidney Hillman Health Center*
Francis J. Coyle	*Community Services Liaison — United Funds and Councils, AFL-CIO*
Stanley J. Cummings	*Uniform Manufacturers Exchange*
Anne D'Este, A.M., R.N.	*American Nurses Association*
Salvatore DiMichael, Ph.D.	*U.S. Dept. Of Health, Education & Welfare, Social & Rehabilitation Service*
Joseph Dorfman	*Amalgamated Clothing Workers of America, New York Joint Board*
Ruth Esterowitz, M.S.W.	*Mental Health-Rehabilitation Program Sidney Hillman Health Center*
Elie Faust	Advance, *Amalgamated Clothing Workers of America*
Henry Foner	*Fur, Leather and Machine Workers Joint Board*
Charles J. Garrahan	*Amalgamated Clothing Workers of America, Shirtmaker's Joint Board*
John J. Gehan, M.A.	*New York City Central Labor Council*

Morty Goldklang	*Amalgamated Clothing Workers of America, New York Joint Board*
Louis A. Goldstein	*Amalgamated Clothing Workers of America, New York Joint Board*
Murray Goldstein	*Amalgamated Clothing Workers of America, New York Joint Board*
Harry Gordon	*Amalgamated Clothing Workers of America, New York Joint Board*
David E. Gould	*American Federation of State, County & Municipal Employees*
Nat Greenberg	*Amalgamated Clothing Workers of America, Local 158*
Hy Greenblatt	*Employees Retirement Fund, Illum. Prod. Ind.*
Bruce B. Grynbaum, M.D.	*New York Department of Hospitals, Rehabilitation Department*
Oswald Gutierrez	*Amalgamated Jewelry, Diamond and Watchcase Workers Union*
Edward Hanin, M.D.	*St. Vincent's Hospital, Department of Psychiatry*
Charles Haskel	*United Federation of Teachers*
Howard Hess, M.D.	*Columbia University*
H. J. Hooven	*Bronx County Society for Mental Health*
Samuel L. Hyman	*Council On Social Work Education*
Shirley J. Jones, M.S.W.	*New York University, Graduate School of Social Work*
Harold M. Kase, Ed.D.	*Altro Health and Rehabilitation Service*
Harry Kauff	*Amalgamated Clothing Workers of America, New York Joint Board*
Father Charles Koerber	*Motivational Guidance Association*

Vincent Lacapria	*Vice-President, Sidney Hillman Health Center*
James L. Lee, Jr.	*International Ladies Garment Workers Union Health Center*
Louis L. Levine	*Deputy Commissioner, New York State Department of Labor*
Sidney Lew	*New York City Central Labor Council, AFL-CIO*
Kenneth G. Lewis	*Utility Workers Union of America, AFL-CIO*
Nick LiCausi	*Amalgamated Clothing Workers of America, New York Joint Board*
Elena Manzanere, Ph.D.	*Psychologist*
Annie B. Martin	*Oil, Chemical and Atomic Workers International Union*
Samuel Masler	*Treasurer, Sidney Hillman Health Center*
Caesar A. Massa	*Retail, Wholesale and Department Store Union*
Lucille Y. Mayo	*Workmen's Compensation Board*
Patricia Meckle	*Communication Workers of America*
Sam Meyers	*United Automobile Workers, AFL-CIO*
M. A. Morehead, M.D.	*Columbia School of Public Health*
Barbara E. Moriarty	*Social & Rehabilitation Services, Department of Health, Education, and Welfare*
Joseph B. Murray	*Welfare & Pension Funds, New York Shipping Association Port Watchmen's Union*
Burton Nackenson, M.D.	*Liaison, Mt. Sinai Hospital & Mental Health-Rehabilitation Program, Sidney Hillman Health Center*
Robert Navarre, M.D.	*Mental Health-Rehabilitation Program, Sidney Hillman Health Center*
Susan Neal, M.S.W.	*Manhattan State Hospital*

Gertrude Neary	*New Jersey Rehabilitation Commission*
Yetta Ostrow	*Mental Health-Rehabilitation Program, Sidney Hillman Health Center*
Elda Patton, M.D.	*Mental Health-Rehabilitation Program, Sidney Hillman Health Center*
Rose Quart	*Fur, Leather and Machine Workers Union, Joint Board*
Elias Rabkin	*Amalgamated Clothing Workers of America, New York Joint Board,* News Record
Vivian Radosta	*Teamster Center, Montefiore Hospital*
Charles P. Regalbuoto	*Plastering Industry, Welfare & Pension Fund*
Benjamin Riskin	*Electrical Radio and Machine Workers Health Fund*
Theodore Rosenthal, M.D.	*Amalgamated Laundry Workers, Health Center*
Harvey Ross, M.D.	*Gracie Square Hospital*
George Rothman	*American Federation of State, County & Muncipal Employers*
Donald Rubin '	*Pocketbook and Novelty Workers Union, Joint Retirement Fund*
Louis Salzman	*New York State Division of Vocational Rehabilitation*
Michael Sampson	*Utility Workers Union of America, AFL-CIO*
Corinne Schreider	*New York City Human Resources Administration*
Sylvia Scribner, M.A.	*Department of Psychology, Albert Einstein Medical Center*
Benny Sher	*Amalgamated Jewelry, Diamond & Watchcase Workers Union*
Sam Shniter	*Amalgamated Clothing Workers of America New York Joint Board*

John J. Sommer, M.S.S.	*Mental Health-Rehabilitation Program, Sidney Hillman Health Center*
Julius Sum	*Retail, Wholesale & Chain Store Food Employees*
Bill Swanwick	*New York City Central Labor Council, Job Development Projects, AFL-CIO*
Angelo Taglialatela	*Amalgamated Clothing Workers of America, New York Joint Board*
Lazare Teper	*International Ladies Garment Workers Union*
Jaime Titievsky, M.D.	*Mental Health-Rehabilitation Program, Sidney Hillman Health Center*
Martin Tolchin	*New York Times*
Racheal Reed, M.D.	*Maimonides Medical Center*
Al Udoff	*Attorney for the Amalgamated Life Insurance Company*
Nilsa Velez	*Mental Health-Rehabilitation Program, Sidney Hillman Health Center*
William J. Walsh	*Communications Workers of America*
Germaine Wasserman	*Fur, Leather and Machine Workers Union, Joint Board*
Gerald R. Waters, Sr.	*New York City Central Labor Council, Job Development Projects, AFL-CIO*
Dena Wechter	*Amalgamated Life Insurance Company*
Hannah Wedeen	*Center for Occupational Mental Health*
Hyman J. Weiner, D.S.W.	*Mental Health-Rehabilitation Program, Sidney Hillman Health Center*
Sadie Zaidens, M.D.	*Sidney Hillman Health Center*
Abraham Zide	*United Furniture Workers Insurance Fund*

DESIGN/Kenneth L. Curtis